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CLINICAL SUPERVISION PLAN
For LGSW and LISW

(Revised August 1, 2012)

▪ GENERAL INFORMATION AND INSTRUCTIONS ▪ ATTACH YOUR POSITION DESCRIPTION TO THIS FORM

PLEASE TYPE OR PRINT CLEARLY IN BLACK INK AND KEEP ALL PAGES OF THIS FORM TOGETHER.

1. Submit a separate Supervision Plan form for each social work position. Please use one form to document supervision from multiple supervisors for the same social work position. **A current Supervision Plan form must be on file with the Board.**
2. Complete the entire form, provide all applicable signatures, and ***ATTACH YOUR POSITION DESCRIPTION*** **for the employment listed below before submitting the form to the Board office, if not previously submitted.**

DATA CLASSIFICATION: Information which you and your supervisor(s) provide on this form is classified as public data. As public data, information will be available to any person upon request.

❑ INITIAL PLAN	❑ REVISED PLAN *(circle change)*:	▪New Supervisor	▪Additional Supervisor	▪Scope of Position	▪Type/Amount of Supervision
		▪Employment			

SUPERVISION START DATE:	EMPLOYMENT START DATE:	AVERAGE NUMBER OF HOURS WORKED PER WEEK:

▪ SUPERVISEE / LICENSEE INFORMATION ▪

LICENSE NUMBER:	LICENSE: *(check **one** box)*	❑ LGSW engaged in clinical social work practice, submitting a Detailed Description of Clinical Practice	❑ LISW engaged in clinical social work practice, submitting a Detailed Description of Clinical Practice

LAST NAME (as it appears on license card):	FIRST NAME:	MIDDLE NAME:

MAILING ADDRESS: (NEW? circle: YES NO)	DAYTIME PUBLIC TELEPHONE:

CITY:	COUNTY:	STATE:	ZIP CODE:

AGENCY/EMPLOYER: (no acronyms)	POSITION TITLE: (no acronyms)

AGENCY ADDRESS: (NEW? circle: YES NO)	LICENSEE EMAIL:

CITY:	COUNTY:	STATE:	ZIP CODE:

▪ CERTIFICATION BY LICENSEE▪

By signing and dating below, I attest that:

1. I have read and understand the supervised practice requirements for licensure and hereby affirm that this plan will be carried out as described. I further understand that a *revised* **Supervision Plan form** must be submitted within 60 days of changes outlined in the Board's Statute, Chapter 148E.125.
2. Failure to submit the **Supervision Plan form** within 60 days after beginning a social work practice position will result in licensee paying the supervision plan late fee specified in section 148E.180 when the licensee applies for license renewal.
3. I understand that I am required to submit a **Supervision Verification form** at license renewal.
4. If my supervisor is licensed as an LICSW in MN, I understand that my social work supervisor must have completed a one-time requirement of 30 hours of training in supervision. Alternate supervisors are not required to meet this requirement.
5. If my supervisor is licensed as an LICSW in MN, I understand that my clinical supervisor must have completed at least 2000 hours of experience in authorized social work practice, including 1000 hours of experience in clinical practice, after obtaining the LICSW license.
6. I understand that if clinical supervised practice begins on or after August 1, 2011, I must complete 1800 hours of "direct clinical client contact", of the 4000 hours of clinical social work practice required.
7. I understand that supervision with an alternate supervisor, under MS 148E.120 subd. 2, may be limited to 25% of the supervision hours required.

LICENSEE/SUPERVISEE SIGNATURE:	**DATE:**

▪ SUPERVISOR #1▪ (Supervisor must complete this section.)

LAST NAME:	FIRST NAME:	MIDDLE NAME:
PRESENT EMPLOYER:	TITLE AT TIME OF SUPERVISION:	
EMPLOYER ADDRESS:		
CITY:	STATE:	ZIP CODE:
SUPERVISOR EMAIL:	DAYTIME PUBLIC TELEPHONE:	

HIGHEST DEGREE:	MAJOR:	DATE DEGREE CONFERRED:	COLLEGE OR UNIVERSITY:
SOCIAL WORK LICENSE NUMBER:	LICENSE HELD:	STATE: **(if other than MN, attach copy of current license)**	EFFECTIVE DATE OF LICENSE:
OTHER BOARD LICENSE NUMBER: **(attach copy of current license)**	LICENSE HELD:	STATE:	EFFECTIVE DATE OF LICENSE:

Average number of hours of supervision provided per month as specified below: _____ **Start date of supervision:** _____

▪ Mandatory One-on-One Supervision Hours (50% required)

- ▪ In-Person hrs/mo _____ (minimum 25%)
- ▪ Eye-to-Eye electronic media hrs/mo _____

▪ Other Types of Supervision Permitted (no more than 50% allowed)

- ▪ One-on-One telephone hrs/mo_____
- ▪ Group hrs/mo_____
  - ▪ Number in group, excluding supervisor(s) _____

NOTE: ▪ Group supervision is limited to 6 supervisees and may include in-person, telephone, or eye-to-eye electronic media.
▪ The supervision must not be provided by email.
▪ **If supervisee began supervision under a Supervision Plan submitted prior to August 1, 2011, any remaining supervised practice hours must comply with the new requirements, as specified in MS148E.**

As a supervisor, I affirm that the content of the supervision will include:

Yes	No	1. clinical practice, if applicable (authorized only for LGSW and LISW)	Yes	No	4. authorized scope of practice
Yes	No	2. development of professional social work knowledge, skills, and values	Yes	No	5. ensuring continuing competence
Yes	No	3. practice methods	Yes	No	6. ethical standards of practice

▪ CERTIFICATION BY SUPERVISOR #1▪

ALL SUPERVISORS: The attached Detailed Description of Clinical Social Work Practice is accurate.	Yes	No
ONLY SUPERVISORS LICENSED AS SOCIAL WORKERS IN MINNESOTA: As a clinical supervisor, I have completed a one-time requirement of 30 hours of training in supervision. I understand this information will be available to the public at the Board's website.	Yes	No
ONLY SUPERVISORS LICENSED AS SOCIAL WORKERS IN MINNESOTA: As a clinical supervisor, I have completed at least 2000 hours of experience in authorized social work practice, including 1000 hours of experience in clinical practice, after obtaining my LICSW license. I understand this information will be available to the public at the Board's website.	Yes	No

By signing and dating below, I attest that:

1. I have read and understand the supervised practice requirements for licensure and hereby affirm that this plan will be carried out as described. I further understand that a *revised* **Supervision Plan form** must be submitted within 60 days of changes outlined in the Board's Statute, Chapter 148E.125.
2. I understand that a **Supervision Verification form** must be submitted at the supervisee's license renewal and when the supervisee applies for another license category.
3. I understand that if clinical supervised practice begins on or after August 1, 2011, 1800 hours of "direct clinical client contact", of the 4000 hours of clinical social work practice required, must be completed to be eligible to apply for the LICSW license.
4. **(If applicable)** I am an alternate supervisor, and I am a currently licensed mental health professional qualified to provide supervision according to my licensing board.

SUPERVISOR #1 SIGNATURE:	**DATE:**

LICENSEE/APPLICANT NAME & LICENSE NUMBER: _____

▪ SUPERVISOR #2▪ (Supervisor must complete this section.)

LAST NAME:	FIRST NAME:	MIDDLE NAME:
PRESENT EMPLOYER:	TITLE AT TIME OF SUPERVISION:	
EMPLOYER ADDRESS:		
CITY:	STATE:	ZIP CODE:
SUPERVISOR EMAIL:	DAYTIME PUBLIC TELEPHONE:	

HIGHEST DEGREE:	MAJOR:	DATE DEGREE CONFERRED:	COLLEGE OR UNIVERSITY:
SOCIAL WORK LICENSE NUMBER:	LICENSE HELD:	STATE: **(if other than MN, attach copy of current license)**	EFFECTIVE DATE OF LICENSE:
OTHER BOARD LICENSE NUMBER: **(attach copy of current license)**	LICENSE HELD:	STATE:	EFFECTIVE DATE OF LICENSE:

Average number of hours of supervision provided per month as specified below: _____ **Start date of supervision:** _____

▪ Mandatory One-on-One Supervision Hours (50% required)

- ▪ In-Person hrs/mo _____ (minimum 25%)
- ▪ Eye-to-Eye electronic media hrs/mo _____

▪ Other Types of Supervision Permitted (no more than 50% allowed)

- ▪ One-on-One telephone hrs/mo_____
- ▪ Group hrs/mo_____
  - ▪ Number in group, excluding supervisor(s) _____

NOTE: ▪ Group supervision is limited to 6 supervisees and may include in-person, telephone, or eye-to-eye electronic media.
▪ The supervision must not be provided by email.
▪ **If supervisee began supervision under a Supervision Plan submitted prior to August 1, 2011, any remaining supervised practice hours must comply with the new requirements, as specified in MS148E.**

As a supervisor, I affirm that the content of the supervision will include:

Yes	No	1. clinical practice, if applicable (authorized only for LGSW and LISW)	Yes	No	4. authorized scope of practice
Yes	No	2. development of professional social work knowledge, skills, and values	Yes	No	5. ensuring continuing competence
Yes	No	3. practice methods	Yes	No	6. ethical standards of practice

▪ CERTIFICATION BY SUPERVISOR #2▪

ALL SUPERVISORS: The attached Detailed Description of Clinical Social Work Practice is accurate.	Yes	No
ONLY SUPERVISORS LICENSED AS SOCIAL WORKERS IN MINNESOTA: As a supervisor, I have completed a one-time requirement of 30 hours of training in supervision. I understand this information will be available to the public at the Board's website.	Yes	No
ONLY SUPERVISORS LICENSED AS SOCIAL WORKERS IN MINNESOTA: As a clinical supervisor, I have completed at least 2000 hours of experience in authorized social work practice, including 1000 hours of experience in clinical practice, after obtaining my LICSW license. I understand this information will be available to the public at the Board's website.	Yes	No

By signing and dating below, I attest that:

1. I have read and understand the supervised practice requirements for licensure and hereby affirm that this plan will be carried out as described. I further understand that a *revised* **Supervision Plan form** must be submitted within 60 days of changes outlined in the Board's Statute, Chapter 148E.125.
2. I understand that a **Supervision Verification form** must be submitted at the supervisee's license renewal and when the supervisee applies for another license category.
3. I understand that if clinical supervised practice begins on or after August 1, 2011, 1800 hours of "direct clinical client contact", of the 4000 hours of clinical social work practice required, must be completed to be eligible to apply for the LICSW license.
4. **(If applicable)** I am an alternate supervisor, and I am a currently licensed mental health professional qualified to provide supervision according to my licensing board.

SUPERVISOR #2 SIGNATURE:	**DATE:**

LICENSEE/APPLICANT NAME & LICENSE NUMBER: _____

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SUPERVISION PLAN ADDENDUM
INSTRUCTIONS FOR DETAILED DESCRIPTION OF CLINICAL SOCIAL WORK PRACTICE

▪ONLY FOR LGSW AND LISW LICENSEES PRACTICING CLINICAL SOCIAL WORK ▪

▪ GENERAL INFORMATION AND INSTRUCTIONS ▪

1. If you are licensed as an LGSW or LISW and are practicing within a clinical scope as defined in Minnesota Statutes, Chapter 148E.010, subdivision 6 (as noted below), you will be required to submit a **Detailed Description of Clinical Social Work Practice.**

2. In addition, when you renew your license or when you apply for the LICSW license, your supervisor(s) must complete a **Supervision Verification** form which includes an attestation that you have "demonstrated skill through practice experience in the diagnosis, treatment, and prevention of mental and emotional disorders."

▪ SUPERVISOR REPORT OF CLINICAL SOCIAL WORK PRACTICE ▪
**(Only supervisors reporting *Clinical Social Work Practice*
for LGSW or LISW licensees refer to this section.)**

▪ INSTRUCTIONS FOR DETAILED DESCRIPTION OF *CLINICAL* SOCIAL WORK PRACTICE ATTACHMENT ▪

Minnesota Statutes, Chapter 148E.010, subdivision 6: "Clinical practice" means applying professional social work knowledge, skills, and values in the differential diagnosis and treatment of psychosocial function, disability, or impairment, including addictions and emotional, mental, and behavioral disorders. Treatment includes a plan based on a differential diagnosis. Treatment may include, but is not limited to, the provision of psychotherapy to individuals, couples, families, and groups.

The licensee must submit a **Detailed Description of Clinical Social Work Practice** signed by the supervisor(s). Please note that it is important to be as specific and thorough as possible. A reference to the attached position description will not be sufficient.

Please attach a typewritten narrative signed by your supervisor which describes each of the following elements:

1. Client population and the range of presenting issues/diagnoses

2. Clinical modalities commonly utilized

3. Diagnostic process, including:
   a) process utilized for determining clinical diagnoses,
   b) diagnostic instruments used, and
   c) role of the licensee/applicant in the diagnostic process.